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Therapeutic alliance and multiple psychotherapy in the context of therapist rotation: Experiences with OLITA

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ABSTRACT

Despite a long tradition of client-centered approaches in addiction therapy, these approaches have not been broadly applied until the 90s of the last century, since treatment programs were predominantly based on behavior therapy. However, due to dissemination of and research on motivational interviewing (MI) over the last 20 years, client-centered therapy has become increasingly accepted in routine care of patients with substance use disorders. Originally, W. R. Miller and S. Rollnick did not establish MI as a brief intervention. Nevertheless, research on MI has mainly been performed within the context of brief interventions. As a consequence, empirically supported client-centered interventions that are based on long-term treatment are largely missing in addiction therapy. OLITA, the **O**utpatient **L**ong-term **I**ntensive **T**herapy for **A**lcoholics, may be one of few exceptions. OLITA is a comprehensive long-term treatment program that is fully compatible with the principles of MI and that combines elements of client-centered and behavior therapy. This review article presents a synopsis of the published literature on OLITA, focusing on aspects of therapeutic alliance and multiple psychotherapy. After a short introduction of the therapy program, we delineate how client-centered therapy is integrated in the context of therapist rotation. The most important data on process–outcome research in OLITA are summarized. Our results suggest that the therapeutic alliance is a major treatment factor that is strongly associated with the eight treatment processes of the TOPPS (Therapy Orientation by Process Prediction Score) that, in turn, is highly predictive of long-term alcohol abstinence. Based on experience of clinical care and training of OLITA therapists, we show in the practical part of this article how to implement therapist rotation and multiple psychotherapy, as well as how to apply communication and interaction skills to build a successful working alliance.

Contents

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1. OLITA: An integrative therapy program

OLITA is a four-step treatment program for alcohol dependence which immediately follows inpatient detoxification and extends over a total period of 2 years (Table 1). The biopsychosocial therapy approach of OLITA aims at an immediate social reintegration of patients under a sheltered psychotherapeutic and medical supervision. For this purpose, important treatment elements of psychiatric patient care, of psychotherapy and of addiction therapy are integrated into a comprehensive, intensive and long-term therapy program (Table 2 and Fig. 1). The high significance of client-centered principles[1] has suggested a comparison with motivational interviewing (MI[2]) as far back as 10 years ago.[3] In fact, especially during the inpatient introductory phase and the outpatient phase I, the OLITA program is highly congruent with MI when a primary goal consists in an encouragement of the motivation to change. But even the larger-scale aims and tasks of therapy during the entire 2 years of treatment in OLITA are to a great extent in agreement with the principles as well as with the rules of communication and interaction of MI. OLITA was devised completely independently of MI as a treatment alternative for chronic alcohol dependent patients. However, regarded from a perspective of general psychotherapy, the combination of client-centered therapy and cognitive behavioral therapy (Fig. 2) into an outpatient program for long-term treatment can be considered as continuation and extension of the MI concept. Based on long-term alcohol abstinence, this setting is particularly suitable for the implementation of extensive and profound changes of behavior and experience, e.g. clarification of individual therapy goals, step-by-step solving of various specific psychological and social problems, discovery and development of particular strengths and resources, training of communication and social interaction skills, development or re-establishment of self esteem, self-acceptance, self-efficacy and confidence, development of functional cognitions and emotions, as well as training in coping with negative emotions. The combination of intensive therapy, long-term treatment and a consequent client-centered communication and interaction style of the therapists[1] takes into account the extremely reduced psychobiological stress tolerance of patients during the early phase of abstinence as well as the chronicity of alcohol dependence.(see 4,5) A pivotal element of OLITA is the therapist rotation, which establishes the basis for a pragmatic implementation of intensive therapeutic outpatient care. Additionally, the therapist rotation constitutes a psychotherapeutic factor which positively affects the treatment success by the main mechanisms of “variety and variation” as well as “congruence and repetition”.[6,7]

Table 1 – Therapy phases of OLITA.

- **Inpatient period:** ***Detoxification*** (2–3 weeks). Patients are visited by OLITA therapists in the emergency department and at the detoxification ward; initial meeting, motivational interviewing, checking of eligibility criteria, obtaining of biopsychosocial history, primary focus on the development of working alliance, exploration of social network, start of daily supervised disulfiram (100 mg) and daily urine analyses
- **Outpatient period I:** ***Intensive phase*** (3 months). Smooth transition from inpatient detoxification to outpatient therapy; daily individual therapy sessions (primarily supportive), practical support of social reintegration, family and marital sessions, home visits, daily supervised disulfiram (100 mg), daily urine analyses for alcohol and other drugs of abuse, aggressive aftercare
- **Outpatient period II:** ***Stabilizing phase*** (3–4 months, according to individual need). Stepwise reduction of session frequency until three times per week, 15 min supportive therapy, increase of interventions to support social re-integration, regular sessions with relatives (according to individual need), supervised disulfiram (400 mg, 3 times a week), urine analyses, aggressive aftercare
- **Outpatient period III:** ***Weaning-off phase*** (6 months). Twice a week individual sessions, 30 min; goals: (1) reaching the first year of alcohol abstinence, (2) stabilization of social re-integration; supervised disulfiram (400 mg, twice a week), urine analyses, aggressive aftercare
- **Outpatient period IV:** ***Aftercare phase*** (12 months). Once weekly group session (OLITA group: mutual help group with supporting therapist), initially weekly individual sessions (30 min), continuous aggressive aftercare; goals: (1) gradual reduction of individual therapy sessions and tapering off supervised disulfiram (400 mg), (2) continuous and regular attendance of either mutual help groups or the OLITA group

Table 2 – Therapeutic elements of OLITA.

- **High frequency short-term individual therapeutic contacts**
  Structured, guarded attachment by supportive, non-demanding short-term sessions; initially 15 min daily, including weekends and holidays; slow tapering off contact frequency aiming at regular and permanent attendance of weekly group sessions
- **Emergency service and crisis interventions**
  In case of emergency patients and their relatives can contact OLITA round the clock on any day of the year
- **Social re-integration and home visits**
  Specific assistance in re-arranging a social network which supports an abstinent lifestyle; explicit collaboration with family members and friends; family and marital sessions; advice and support regarding occupation, authorities, housing problems, moving, job seeking, financial and legal problems
- **Induction of alcohol intolerance**
  Use of disulfiram (Antabuse®), so-called alcohol deterrent medication. The inhibition of the alcohol-metabolizing enzyme acetaldehyde dehydrogenase leads in case of alcohol consumption to accumulation of toxic acetaldehyde resulting in an "inner poisoning", the so-called "disulfiram-ethanol reaction", comprising extensive flushing, hyper- or hypotension, tachycardia, nausea, vomiting, anxiety
- **Introduction of control factors**
  Supervised intake of alcohol deterrents and explicit exploitation of its psychological effects. Regular urine and blood analyses for alcohol and other drugs of abuse; if necessary, additional breath tests
- **Aggressive aftercare**
  Aggressive therapeutic interventions to immediately interrupt beginning and to prevent threatening relapses: Patients who miss a therapeutic contact are called on to continue therapy or to restart abstinence; examples for aggressive aftercare are spontaneous home visits, telephone calls, mail correspondence and involvement of close friends/relatives
- **Therapist rotation**
  An interdisciplinary team of 6–7 therapists is treating the patients (supervising psychiatrist, psychologist, physician, social worker, nurse and MD/PhD students). According to the concept of therapist rotation, all therapists are equally responsible for all patients, i.e. there are no dyadic patient–therapist relationships, but each therapist is conducting therapy sessions with every patient. As a consequence, the single dyadic therapeutic relationships are replaced by a network of multiple therapeutic relationships. Therapists change in irregular order between the therapeutic sessions, and it is not up to the patients to decide who they are going to talk to. The classical fixation of a single patient to a single therapist is abandoned, and the introduction of new team members is facilitated

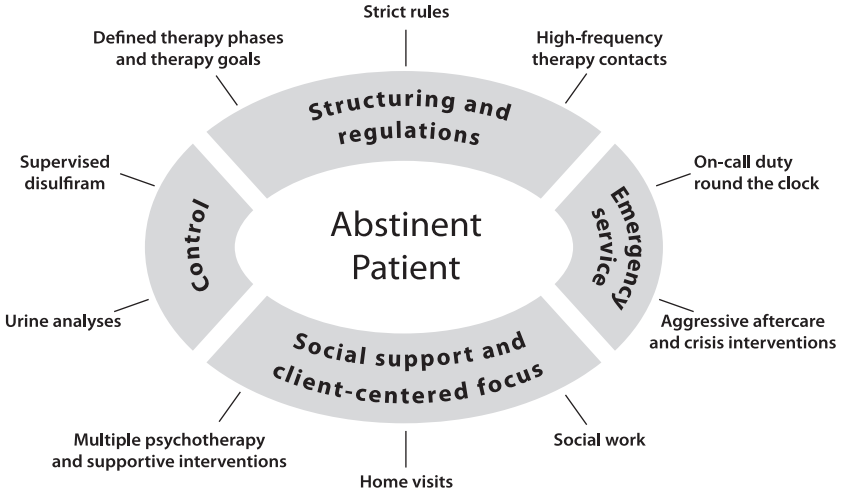

Fig. 1 – Therapy setting of OLITA.

1.1. *Principles of innovative and empirically supported outpatient psychotherapy of alcohol dependence*

It seems expedient to start out with introducing the general therapy principles OLITA is oriented on. That way, the position of this program in the framework of current addiction therapy approaches can be made transparent and the context can be shown, in which therapists in OLITA combine methods of client-centered and cognitive behavioral therapy. The principles have been derived from data on epidemiology, pathogenesis, course and treatment outcome of alcohol dependence:[details in 8–10]

- **Strict abstinence orientation:** Alcohol dependence is an irreversible and incurable disease. Only consistent long-term abstinence can stop the progression of symptoms

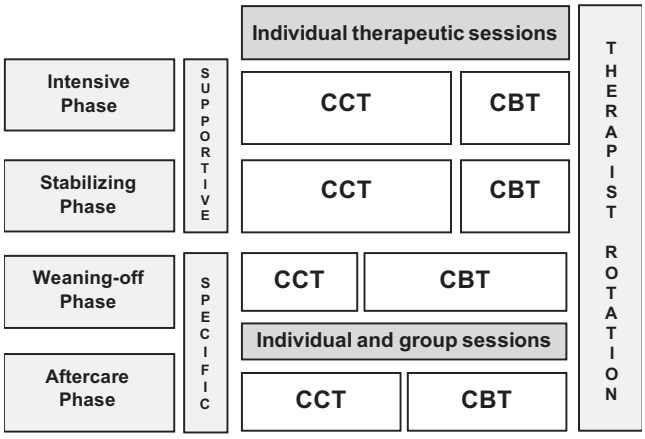

Fig. 2 – Psychotherapy in OLITA – gradual emphasis of specific therapy approaches: Basic concept of the relative proportions of client-centered therapy and cognitive behavioral therapy during the four therapy phases. Individual modifications/adaptations of therapy processes are made according to the patients' needs. CCT: Client-Centered Therapy; CBT: Cognitive Behavioral Therapy.

and support the recovery process. Therapy approaches which involve so-called "controlled drinking" are contraindicated for alcohol dependent patients.

- **Supportive, non-confronting therapist behavior:** Alcohol dependent patients show a severe reduction of psychobiological stress tolerance during the first months of abstinence, which only recovers slowly. While a confrontational and emotionally stressful therapist attitude is contraindicated, a supportive approach that is based on client-centered and cognitive-behavioral treatment strategies has proven effective.
- **Chronic disease – intensive and long-term treatment:** Chronic alcohol dependence is based on a genetic disposition, irreversible neurobiological damage and decades of self-destructive learning processes. Such kind of chronic disorder can only be treated in the framework of a long-term and comprehensive therapy, which may have to continue the whole lifetime. Brief interventions are at best suitable for less chronic conditions of alcohol abuse and risky consumption.
- **A relapse is an emergency:** Alcohol dependence clearly is a very severe disease with high rates of comorbid somatic and psychiatric disorders, social problems, with a high chronicity and a significantly elevated mortality risk. Any relapse not immediately interrupted reinforces the underlying vicious circle. For this reason a relapse is, like in any other chronic and severe disease, an emergency demanding immediate crisis intervention.

1.2. *Building multiple therapeutic relationships by therapist rotation*

The treatment elements of OLITA seem contradictory if regarded superficially. Control, alcohol deterrent medication and strict rules are accompanied by supportive interventions, empathic and accepting counselling, emergency service and crisis intervention round the clock, as well as case management (Fig. 1). For this unusual combination of key components to result in a harmonious treatment program, the therapists indicate even during the very initial therapy sessions the fact that *two* common factors are behind the individual treatment elements, which are

1. **A differentiated disease concept of alcohol dependence and**
2. **A readiness to take on responsibility for the patients.**

This attitude can be communicated in an authentic way and be put into practice only by intensive relationship building. The therapist rotation was developed as a form of building multiple therapeutic relationships, in order to guarantee the formation of a working alliance, which is feasible in the framework of high treatment intensity and session frequency of the OLITA program. With therapist rotation the patients work with several equally responsible therapists who conduct the sessions according to the principle of rotation in informal and not-prefixed alternation.

An eclectic and applicatory definition of the therapeutic alliance is the prerequisite of building multiple therapeutic relationships by a collaboration of several therapists:

An efficient therapeutic alliance is a unique interpersonal working relationship established by the therapist by means of empathy, emotional warmth and genuineness. Thus, an alliance can be formed between patient and therapist that is characterized by mutual trust, positive regard and acceptance, but also by responsibility and commitment. For the patients the therapeutic alliance presents the basis on which they are able to clarify the aims of the therapy, solve specific problems, discover and develop their own strengths and personality, and finally enhance their general well-being.[3]

In working with addicted patients, the importance of building a stable therapeutic alliance proves especially important in the initial phase of therapy. Frequently patients regard therapists as being affiliated with a system which they had to mislead in order to survive. Thus it comes as no surprise that representatives of different approaches in addiction therapy concede high significance to an early development of a working alliance.(e.g. [2,11–13])

There are mainly two reasons from clinical practice that argue against the implementation of the classical system of single dyadic, i.e. one-to-one, therapeutic relationships in long-term therapies:

1) Any long-term dyadic therapy of chronic psychiatric patients involves a risk of the patients developing an interpersonal dependency on their reference therapist; in case of vacation, illness or resignation of that therapist from the institution, the danger of severe alliance ruptures or even destructive crises of the patients is therefore a distinct possibility. Major problems are the absence of the familiar reference therapist, the assignment of a "substitute therapist", as well as a change of location of a therapist, which in today's professional world is a frequent occurrence. These events constitute especially for patients suffering from a severe personality disorder a catastrophe of major extent that often results in a relapse or an exacerbation of the psychiatric symptoms of the patients.

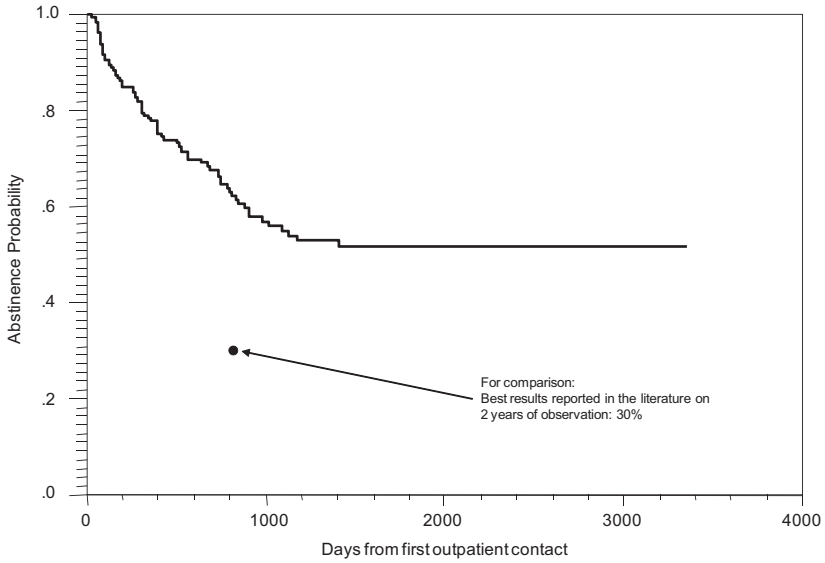

Fig. 3 – The cumulative abstinence probability during the 9-year study is 52% for the complete sample of OLITA patients (N = 180).

2) The therapists would rapidly be overtaxed concerning the demands on their time as well as on their emotions if responsible on their own for a certain number of patients treated in an approach comprising initially daily contacts, round-the-clock emergency service and a two-year treatment period. As a consequence, they continually would have to alternate between intensive phases of work and extended phases of vacation as overtime compensation, in order to stay operational and healthy. These frequent changes in reference therapist, however, would in turn put a heavy burden on the therapeutic relationship and the entire therapeutic process.

In a *systematic* treatment by several equally responsible therapists from the outset, however, the patients would be able to experience a maximal amount of therapeutic alliance without running into danger of getting dependent on an individual therapist. The concept of "multiple psychotherapy" described by Alfred Adler around 1920 represents a significant approach to resolving this drawback of conventional psychotherapy. It regrettably has, however, never been adopted to a larger extent.(see [14]) Completely independently of the multiple psychotherapy, the therapist rotation was designed at OLITA 70 years later on. It was the only way to systematically combine the high-frequency contacts of an intensive cognitive behavioral addiction therapy with the client-centered basic variables indispensable for the formation of a therapeutic relationship, namely empathy, unconditional positive regard and congruence. The therapist rotation this way makes it possible to implement OLITA on a day-to-day basis. This method of creating multiple therapeutic relationships is completely new in the treatment of patients with substance use disorders. It has proven its clinical worth during more than 10 years of the OLITA pilot study and is amazingly resistant to the shortcomings of dyadic therapies delineated above.

2. Outcome research on OLITA

A total number of 180 severely affected alcohol dependent patients (144 men, 36 women) were consecutively included into the OLITA pilot study. At the beginning of therapy, patients were on average 44 (SD = 8) years old, had a duration of alcohol dependence of 18 (SD = 7) years, with a daily intake of 437 (SD = 162) gram of pure alcohol, approximately 7 (SD = 9) prior inpatient detoxification treatments, and 1 (SD = 1) failed inpatient long-term therapy. A total of 58% of the patients were unemployed, 81% suffered from comorbid psychiatric disorders (mainly anxiety, depression and personality disorders). 30% showed severe suicide attempts in their case history. Also the physical impairment of patients was serious: While a mere 11% were diagnosed with mild sequelae of alcoholism (e.g. fatty liver), 33% suffered from considerable (e.g. epileptic seizures during detoxification), 44% from severe (e.g. polyneuropathy) and 13% from very severe (e.g. liver cirrhosis) sequelae of alcoholism. Considering this severely affected population of alcohol dependent patients, the long-term success-rate of OLITA is incredibly high: More than 50% of the patients remained abstinent over up to 7 years of post-treatment follow-up (Fig. 3). The literature generally reports abstinence rates of <30% in follow-up periods of less than 1 year (very rarely more than 2 years). Based on this high abstinence rate, the patients achieved a tremendous improvement in psychological, biological and social parameters. The unemployment rate declined from 58% to 22% in an area (Göttingen) with a general rate of unemployment of 17%, and comorbid psychiatric disorders (mainly anxiety and depression) showed a substantial decrease during treatment from 60% in the first month of therapy to 13% at therapy end after 2 years.(details of therapy outcome studies in [5,10,15–19])

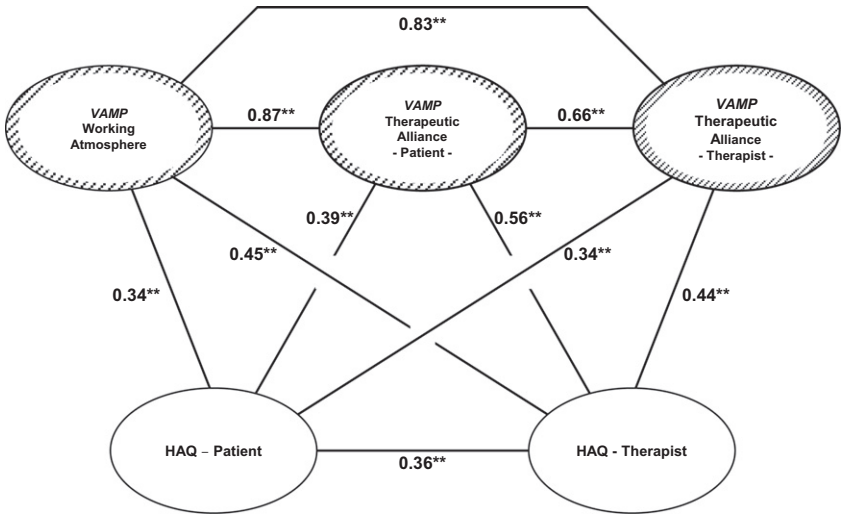

Fig. 4 – Construct validity: Aspects of the therapeutic alliance at the beginning of therapy (t_1, n = 64); correlational pattern between the observer-rated VAMP scales (fascinated) and the self-reported Helping Alliance Questionnaire (HAQ) (white).

3. Process–outcome research on OLITA

In contrast to the psychotherapy of depression and anxiety, there are hardly any prospective long-term studies in addiction therapy, which analyse the change processes in the course of successive therapy sessions by means of behavior observation. In a recent process–outcome research project, we therefore investigated psychotherapeutic treatment processes of 64 patients during the first year of OLITA at three time points, t_1 (week 3), t_2 (month 6) and t_3 (month 12).[20–22] As a diagnostic instrument we developed the "Video-Assisted Monitoring of Psychotherapeutic Processes in Chronic Psychiatric Disease (VAMP)". This observational system was derived from models of change processes in general psychotherapy and addiction therapy. VAMP is based on the ratings of transcribed video recordings of therapy sessions and enables the assessment of patient-related therapeutic processes from a macro-analytical as well as from a micro-analytical perspective. It comprises the scales "Common psychotherapeutic factors", "Addictive behavior", "Disease concept", "Working atmosphere and therapeutic alliance", "Psychopathological symptoms" and "Problem solving and processing". The composition of the VAMP scales has proven suitable to measure important psychotherapeutic contents of OLITA. Furthermore, the factors assessed by the VAMP once again underline the high compatibility of OLITA and MI, because common psychotherapeutic factors, alliance and addiction processes are likewise amongst the central therapy processes of MI. An investigation of MI treatment processes with the VAMP might actually present the topic for an exciting innovative research project. Regarding psychometric quality, the VAMP shows high reliability (median inter-rater reliability of 0.80; median internal consistency of 0.81), as well as impressive construct validity in terms of intercorrelational patterns of theoretically associated factors. Construct validation of the therapeutic alliance scales resulted in pronounced correlational patterns between alliance ratings of observers (VAMP), patients (HAQ-P) and therapists (HAQ-therapist) (Fig. 4). As

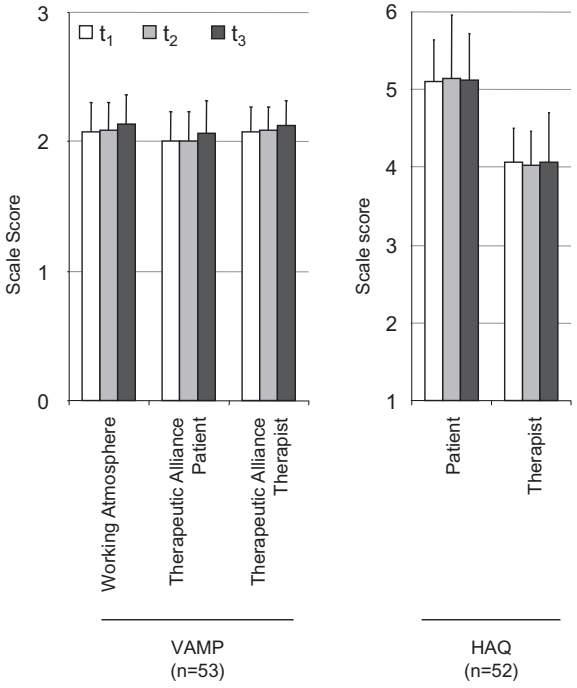

Fig. 5 – Trajectory of therapeutic alliance during the first year of therapy; neither observer-rating (VAMP scales) nor self-rating (HAQ-P, HAQ-T) show statistically significant changes between t_1, t_2 and t_3; repeated measures ANOVA. VAMP scales: Working Atmosphere, Therapeutic Alliance – Patient, Therapeutic Alliance – Therapist (n = 53); HAQ scales: HAQ-Patient, HAQ-Therapist (n = 52).

self-report measure, the Helping Alliance Questionnaire (HAQ[23,24]) was used in the VAMP study. The HAQ is available in a German translation as a patient form and also as a therapist form so that both interacting partners can give a subjective rating of how they have experienced the therapeutic alliance during the session just conducted.[25] The question-

Table 3 – The eight therapy processes of the TOPPS (Therapy Orientation by Process Prediction Score).

(1) **Experience of resources:** To what extent are patients aware of resources, e.g. their own internal possibilities, capabilities, potentials and strengths, as well as external resources and facilities?
(2) **Abstinence self-efficacy:** How confident are patients to resist drinking alcohol when being confronted with situations that have a high relapse risk?
(3) **Implicit craving:** To what extent do patients show conspicuous behavior that, according to clinical experience, often occurs before an alcohol relapse without being explicitly experienced by the patients as alcohol craving?
(4) **Relapse alertness:** How much do patients pay attention to measures to protect themselves of high risk situations?
(5) **Relapse risk:** Global judgment that includes external indicators of threatening alcohol consumption, as well as abstinence confidence, craving, relapse alertness
(6) **Dysfunctional problem processing of current problems:** To what extent do patients deal with their current problems and associated conditions in a way detrimental to their health, destructively and inadequately?
(7) **Dysfunctional therapeutic engagement:** How strongly do patients exhibit destructive engagement concerning the therapy process, e.g. lack of motivation, late arrival, indifference regarding cooperation, and in extreme cases, animosity/hostility?
(8) **Subjective disease concept:** How differentiated and elaborated are the subjective beliefs of the patients regarding their alcohol dependence?

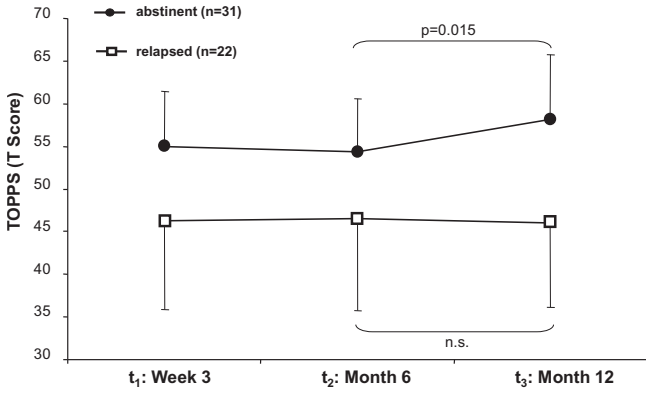

Fig. 6 – Trajectory of the TOPPS during the first year of therapy (Therapy Orientation by Process Prediction Score); repeated measures ANOVA ($n = 53$); abstinent versus relapsed patients ($p < 0.001$), $t_1 \rightarrow t_2 \rightarrow t_3$ (n.s.).

naire is based on two common factors of the therapeutic alliance: Support by the therapist and collaborative teamwork of patient and therapist regarding the treatment goals. The 11 items are answered on a 6-point Likert scale directly after a therapy session (1 = "I strongly disagree" to 6 = "I strongly agree"). The total score equals the mean of all 11 items. High reliability and sound validity of the English and German version are well documented.[25–30] In the VAMP study, patients and therapists rated a total of 15 therapy sessions during the first year of OLITA with the HAQ (weeks 1–8, months 3–9, and finally month 12). The HAQ-patient (Cronbach's α, median: 0.89, range 0.82–0.92) as well as the HAQ-therapist (Cronbach's α, median: 0.82, range 0.74–0.89) showed a high internal consistency at all 15 assessment time points.

3.1. *Course of the therapeutic alliance during the first year of therapy*

A total of five raters assessed the therapy processes with the VAMP at t_1 (week 3), t_2 (month 6) and t_3 (month 12), and the mean ratings of all raters were statistically analysed as primary process measures. Aspects of the therapeutic alliance are represented by three VAMP scales: Working atmosphere, Therapeutic alliance-patient and Therapeutic alliance-therapist. Surprisingly, we did not find any statistically significant changes over time between t_1, t_2 and t_3 in any of these observer-rated alliance measures. Also the alliance self-ratings of patients and therapists with the HAQ did not show statistically significant changes between the three time points (Fig. 5).

Table 4 – Cox regression analyses to predict time to relapse during four-year follow-up by TOPPS, VAMP therapeutic alliance scales, HAQ-Patient and HAQ-Therapist.

Predictors	B			SE (B)			Wald χ^2			*p*-Wert		
	t_1	t_2	t_3	t_1	t_2	t_3	t_1	t_2	t_3	t_1	t_2	t_3
TOPPS	−0.08	−0.06	−.09	0.02	0.02	0.02	20.63	10.90	17.71	<0.001	0.001	<0.001
VAMP: Therapeutic alliance – observer rating												
Working atmosphere	−0.15	−0.45	−1.12	0.79	0.85	0.98	0.04	0.28	1.29	0.846	0.595	0.255
Therapeutic alliance - Patient	−0.61	−0.50	−1.42	0.74	0.74	0.75	0.69	0.45	3.64	0.407	0.503	0.056
Therapeutic alliance - Therapist	−0.69	−0.32	−0.29	1.05	1.12	1.08	0.44	0.08	0.07	0.509	0.773	0.787
HAQ: Therapeutic alliance – self rating												
HAQ - Patient	−0.32	−0.33	−0.16	0.32	0.21	0.32	0.95	2.52	0.25	0.329	0.112	0.620
HAQ - Therapist	−0.85	−0.83	−0.79	0.37	0.46	0.31	5.27	3.29	6.52	0.022	0.070	0.011

Sample size: TOPPS, VAMP scales: t_1: $n = 64$; t_2: $n = 58$; t_3: $n = 53$;
HAQ: t_1: $n = 64$; t_2: $n = 57–58$; t_3: $n = 52–53$.

Table 5 – Correlations between TOPPS and measures of therapeutic alliance.

	TOPPS		
	t_1	t_2	t_3
Therapeutic alliance			
VAMP: Working atmosphere	0.48**	0.67**	0.61**
VAMP: Therapeutic alliance – Patient	0.60**	0.72**	0.70**
VAMP: Therapeutic alliance – Therapist	0.43**	0.54**	0.31*
HAQ – Patient	0.43**	0.39**	0.32*
HAQ – Therapist	0.57**	0.53**	0.42**

Sample size: t_1: $n = 64$; t_2: $n = 58$; t_3: $n = 53$.
* $p < 0.05$.
** $p < 0.01$.

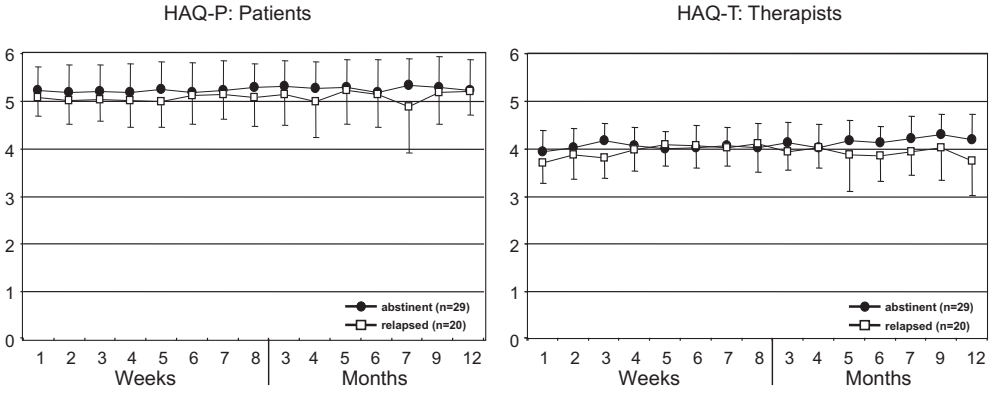

Fig. 7 – Trajectory of the therapeutic alliance, self-rating of patients (HAQ-P) and therapists (HAQ-T) during the first year of therapy of patients with long-term abstinence and patients who relapsed after month 12 of therapy; in both groups there are no statistically significant changes over time.

3.2. *Prediction of the cumulative abstinence probability over up to 4 years*

Of all 28 therapy processes assessed by the VAMP, those eight with the highest validity to predict long-term alcohol abstinence were combined into a composite score, the TOPPS (Therapy Orientation by Process Prediction Score): Experience of resources, abstinence self-efficacy, implicit craving, relapse alertness, relapse risk, dysfunctional problem solving of current problems, dysfunctional therapeutic engagement, and subjective disease concept (Table 3). The higher the TOPPS score is, the more functional are the psychotherapeutic treatment processes of a patient. To facilitate interpretation, TOPPS row scores were transformed into T scores (M of 50, SD of 10). The internal consistency of the TOPPS amounted to Cronbach's alpha values of 0.77 at t_1, 0.79 at t_2 and 0.77 at t_3. Repeated measures ANOVA showed that patients who relapsed after the first year of therapy differed significantly from long-term abstinent patients at all three assessed time points in their TOPPS score ($F = 28.11$, $df = 1$, $p < 0.001$). The ANOVA model, however, does neither show a significant effect for change over time, nor a significant interaction effect between time and abstinence status (Fig. 6). While patients who relapsed after 1 year showed consistently low TOPPS scores from the beginning of therapy, patients managing long-term abstinence showed high TOPPS scores at t_1 which did not change until t_2 but increased slightly between t_2 and t_3 ($T = -2.58$, $df = 30$, $p = 0.015$). For clinical practice a simplified version of TOPPS in form of a checklist was developed.[22]

Regarding the prediction of cumulative abstinence probability by the therapeutic alliance, the results were heterogeneous (Tables 4 and 5): Both the VAMP observer-ratings and the HAQ self-ratings of patients failed to statistically significantly predict abstinence probability. The HAQ ratings of therapists, however, were able to make statistically significant predictions at time points t_1 ($p = 0.022$) and t_3 ($p = 0.011$), and statistically borderline significant predictions at time point t_2 ($p = 0.070$) (details in Table 4). Interestingly, all alliance parameters were considerably correlated with the TOPPS (Table 5) that in turn was highly predictive of the cumulative abstinence probability at all three time points t_1 ($p < 0.001$), t_2 ($p = 0.001$) and t_3 ($p < 0.001$) (Table 4).

3.3. *Stability of the therapeutic alliance over 15 measurements during first year of therapy*

Fig. 7 shows the 15 HAQ ratings of patients and therapists, separated into long-term abstinent patients and patients with a relapse after the 12th month of therapy. In a pattern typical for alliance research, the assessments of the patients are more positive than those of the therapists. Similar to the comparison of only three time-points (Fig. 5), there are no significant changes to be found between all 15 time points (analyses were carried out with linear mixed models for time

trends with repeated measures: HAQ-patient $p = .210$; HAQ-therapist $p = .114$).

3.4. *Discussion of process–outcome research on therapeutic alliance in OLITA*

With its moderate influence on therapy outcome, the clear association with the TOPPS and stable high levels during the first year of therapy, the therapeutic alliance forms a central therapy process of OLITA. From a clinical perspective, it represents the supportive and confidence-building context during the entire therapy, in which those processes subsumed in TOPPS are established, which ultimately are stronger associated with treatment outcome. The high quality and stability of self-rated therapeutic alliance found in the VAMP study were measured with questionnaires based on a psychodynamic alliance concept involving reference therapists. This clearly indicates that patients are able to form stable and intensive working relationships in the setting of the therapist rotation. But to which extent are the data of the VAMP study in agreement with results of previous studies on therapeutic alliance in general psychotherapy and addiction therapy? Meta-analyses and literature reviews consistently report moderate but significant correlations ($r = 0.22–0.29$) between the quality of therapeutic alliance and therapy outcomes in general psychotherapy.[31–33] Review articles on the therapeutic alliance in addiction therapy confirm this association but interestingly, the primary outcome of most addiction studies was not abstinence but treatment retention rate.[7,34] Taken together, we can conclude that the significant but moderate prediction of cumulative abstinence probability in the VAMP study is in accordance with the results of process–outcome studies in general psychotherapy and addiction therapy. The fact that the therapists' alliance ratings are significantly higher correlated with substance use outcome than the patients' ratings was also found in other addiction therapy studies.[e.g. 35–37] In contrast, in general psychotherapy commonly the patients' ratings are more strongly associated with therapy success than the therapists' ratings.[31] In comparison with other applications of the German HAQ, the alliance scores in the VAMP study are exceptionally high. [e.g. 25,28–30] The high alliance scores lasting over 12 months are reflected in the ratings of patients, therapists and observers. These new results ought to encourage replication studies in addiction therapy.

4. Practice of building multiple therapeutic relationships by therapist rotation

In OLITA, therapeutic sessions are by far more frequent than in any other form of therapy because of the initially daily contacts. In order to be able to implement the intensity of treatment in practice, the sessions are conducted according to the principle of rotation: An interdisciplinary team of 6–7 therapists is jointly responsible for all patients (supervising psychiatrist, psychologist, physician, social-worker, nurse and MD or PhD students).

The relinquishment of the classical approach of a system of reference therapists does not, however, mean that at the same time the creation of a therapeutic relationship is being neglected. Quite to the contrary: The most important aim at the very beginning of the therapy is to establish trusting working relationships between the patient and all therapists. In order to facilitate this, the therapists are trained extensively in general alliance-building communication and interaction skills (Box 1 and 2), as well as in special therapy skills for the treatment of addiction and comorbid disorders. Most notably, they get acquainted with a new therapeutic attitude: Every therapist is responsible for every patient. This makes great demands on the personalities as well as on the social competence of the individual therapists. Modern competences like openness, flexibility and team spirit, but at the same time old-fashioned qualities like humility, considerateness and diligence are basic prerequisites for building a network of multiple therapeutic relationships.

Box 1 Therapeutic communication and interaction skills to build a successful working alliance (*T: Therapist*).

- **Discreet politeness:** Keeping the scheduled appointment, friendly greeting, addressing the patients by name and shaking their hand, offering a seat, balancing proximity and distance in the seating arrangement, no permanent intrusions during the therapy session (e.g. no beeper, telephone, mobile phone, or abruptly leaving the room), friendly farewell at the end of the session.
- Communicating **calmness**, paying complete **attention** to the patient: Finding inner peace oneself, adjusting one's body position to the patient and looking at him.
- **Open body language, gesture, facial expression:** Leaning forward; keeping the arms open; making eye contact and keeping it, but also being flexible in breaking it and taking it up again (no starring); taking care that there is no hierarchy in the seating arrangement of therapist and patient (e.g. same seat height, same chairs).
- **Client-centered atmosphere:** Offering the time of the therapeutic session to the patients; they are the ones who decide what to talk about, are the focus of attention and do not have to feel ashamed for anything; the patients are also allowed to be silent, calm down and relax (*T: "The daily 15 minutes are completely yours. You decide what we talk about, how much and what you would like to reveal about yourself. The therapists' job is mainly to listen and also to ask so that we better get to know you and your point of view.* [After the patient's response] *...What would you like to talk about today?"*).
- **Attentive listening with genuine interest,** mainly expressed by **non- and paraverbal communication:** Smile, facing body position, nodding; paraverbal utterances like 'um, well, aha'; pleasant medium-loud clear voice, flexible modulation of loudness, medium-fast to slow pace of talking; general goal is encouraging the patient to keep talking.
- **Refraining from interfering:** Letting the patients finish speaking; keeping own advice, interpretations and opinions to a minimum; leaving the patients time to gather their thoughts; being able to endure unpleasant emotional states (the patient's as well as one's own).

- **Empathic listening,** i.e. opening oneself to the emotions, thoughts, aims, wishes, attitudes and values of the patients, freeing oneself from prejudices and criticism as far as possible; trying to empathically understand the patients experience in their internal frame of reference. Empathy is signaled by the therapist's showing that he listens. Reporting back to the patient what the therapist has understood. This happens **(1) by giving simple, summarizing feedback** of the essential statements; in doing so, verbatim repetitions are allowed *(T: "You just said that your colleagues talk to you less and less, they give you strange glances and whisper behind your back.")*, **(2) by statements reflecting back the emotional meaning and impact of what the patient said** *(T: "It makes you uncomfortable that...")* or **(3) by correct continuation of the conversation and asking elaborative questions** *(T: "Could you please try to describe how you experienced the situation at the office yesterday. Your colleague suddenly became silent when you entered the room. What did you think at that moment ...")*.
- **Honestly asking for more information** in case of lack of understanding and clarity *(T: "I have to admit that I have not yet understood completely. Would you please explain this to me once more?")*.
- **Asking open questions:** These are questions which the patient cannot answer to by a short "Yes" or "No", which are not suggestive, and which invite the patient to give extensive answers (*T: "How was it yesterday when you ... " instead of "Wasn't it like this yesterday, that you ..."; "How do you think about ..." instead of "Do you think about this topic like ..."*).
- **Having compassion:** Taking care of the patient in case of grief and sadness (*T: "I am very sorry about this. This must be terrible for you ... ", "It is very difficult for you to have gone through such an experience"*); sharing happiness when the patient feels happy *(T: "This is great! Congratulations, I am very happy for you that ...")*.
- **Showing solidarity:** Giving emotional and practical support to the patients when they have experienced discrimination, have been offended and / or stigmatized; i.e. actively taking measures and giving a personal statement, e.g. phoning officials in charge or medical doctors etc. and informing about important issues like addiction and disease model; mediating, participating in constructive problem-solving, taking the patients' side; if necessary, complaining officially about discrimination and accusing responsible people.
- **Praising** of functional and constructive statements and actions *(T: "It is excellent how you solved the problem ...")*.
- **Competence:** When required give extensive biopsychosocial information about addiction, psychiatric and medical comorbidity, psycho- and addiction therapy; use clear and easily understandable language, avoid a patronizing way of teaching.
- **Giving a clear opinion concerning addiction:** Specify alcohol dependence as a severe disorder / disease with a chronic course and a high treatment need.
- **Giving a clear opinion concerning rules and control factors of OLITA:** Communicating that the strict rules of the therapy program are based on a differentiated disease model of alcohol dependence (e.g. chronic impairment of self-regulation and executive functions; self-perpetuating processes of loss of control; describing strategies of concealing as part of a chronic and stable dysfunctional behavior pattern that will be extinguished and replaced by functional behavior during long-term therapy). Rules may therefore offer a clear help to orientation, planning, decision making, well-organized action and self-evaluation.
- **Reliability and professionalism:** Being informed about the current situation of the patient and the recent therapy session (*T: "Yesterday, you talked with my colleague, Mrs X, about a quarrel that you had with your partner. You decided to do the first step of reconciliation and arrange a nice evening for the two of you. How was it going on?"*); checking whether agreements have been kept and homework has been done (*T: "At first, I would like to suggest that we go over your activity diary ... "*). In case the patient has been promised a specific service, keep the promise (e.g. to issue a certificate, searching for specific information, reviewing the results of a blood test, analyzing a psychological test, arranging an appointment at the general practitioner, making together with the patient a phone call at a public authority).
- **Sharing responsibility:** Communicating that therapy success is based on two essential factors (1) Intensive and conscientious collaboration of the patient and therapists, (2) the therapeutic team offering continuous high-quality support (*T: " Whenever you feel like, you can call the OLITA team. What would help you to really do this when you feel unwell?"*).
- **Supportive interventions:** Taking also apparently little problems serious (e.g. making a shopping list, planning the house-cleaning), collaborative developing of simple methods of problem-solving, letting the patients carry out and train the problem-solving strategies, immediate corrections of possible mistakes. Attaching equal importance to psychotherapy and social work (e.g. therapist accompanies patient to the job center). Active support in case the patient is not yet strong enough or still too exhausted to perform a specific task (basic procedure like in work out / fitness training at a gym: Athletes with little power start with light weights and increase weight slowly; the coach is immediately correcting mistakes of work movement and does not help weight lifting before the power of the athlete starts to decrease).
- **Recognizing little and great resources, efforts and achievements of the patient,** give open feedback and praise: Show respect and positive regard in order to support growth of self-esteem, self-efficacy and hope (*T: "Awesome! This is great how you did ... ", "I am very impressed by the way you ... ", "This is a great achievement of you that ...."*). **For problem-solving always**

build upon existing skills and resources of the patient: How did he solve a similar problem in the past? Which of his strengths can he use to address the current problem? Being aware of the variety of resources, e.g.: courage to join detoxification treatment; self-disclosure at conversations; recent therapy progress; engagement at work; responsibility for the family; interest in TV, books or news; having hobbies; being nicely dressed; enjoying a walk; talking about childhood memories ...).

- **Focusing on goals, affirming and encouraging the patient:** Encouraging optimistic, hopeful, and meaningful perspectives; affirming the patients that they are on the right way, e.g. by elaborating specific positive goals that can be achieved by being alcohol-abstinent (*T: "When yesterday my colleague visited you for the first time, you told him that because of drinking alcohol you had stopped doing a lot of things that you had enjoyed in former times. Then you said that you want to start doing these activities again. What about collecting today all possible ideas concerning pleasurable activities - everything that comes into your mind ...".* Remembering the patients vividly of their therapy goals when they experience difficult stressful states of doubt and hesitating (*T: "Your current situation reminds of that of a hiker who has to walk a particularly difficult and hard trip. In such hard times it happens that the hiker does not know anymore why he is doing this hike at all, and everything that he feels is how each single step is painful and hard, and then he is asking himself about why he is doing this trip at all – some hikers report that in those situations it is helpful that they imagine the goal of the trip with an inner vivid image ...";* when necessary encourage the patients to flexibly amend and transform goals (*T: "When a trip becomes to be to hard it is a good strategy that the hiker allows himself to take a break, to arrive the goal at a later time or to climb up the lower of the two mountain peaks ... "*).
- **Directive, but careful managing of the therapy process,** e.g. by encouraging to analyze problems and to search for strategies to solve them (*T: "You have just explained very well why it is so difficult for you to visit the employment office. Please let us now think about what might help you to ...*); addressing inconsistencies in a careful, accepting and respectful way (*T: "You told me how important it is for you to experience life in an authentic and pure way – on the other hand you are missing the experience that you had after having drunk two liters of wine. Could you please describe whether and how these two desires can be brought in line ...*").
- **Dissolving destructive intensive experiences of problems:** Showing sympathy (*T: "It is tantalizing for you that you cannot fall asleep, and then, craving for alcohol emerges ... "*); splitting the topic into concrete current subproblems (*T: "Let us look at how your evenings are. Please tell me how you felt yesterday when you wanted to go to bed ...*"), focusing on resources of the patient (What are his skills? Which personal strengths does he have? What other resources can be found in the social network? How did he solve a similar problem before? (*T: "To my opinion, it is a great achievement that you stayed sober last night. How did you do this? ...*). Explicitly make small steps (*T: "For you it is essential to find again a normal way of falling sleeping, and at the moment you are doing the best to foster a good sleep: You are staying sober. As you know, alcohol consumption has severely confused the endocrine balance of your body, and this is a major reason for sleeping disorders. Would it be possible that you give your body some more time to recover? The recovering process is comparable with other changes that you know, for example work out in the gym or fitness training, or learning a foreign language. On the one hand, change will not happen all at once but it will progress step-by-step, and finally you will succeed ..."*).
- **Making short summarizing statements** about what the patient said; balancing understanding and asking, so that the patients are able to correct when they feel misunderstood (*T: "Well, I would like to summarize what we were talking about until now, and which conclusions we have made ..."; "Did I understand everything correctly?", "Is it correct how I summarized our conversation?"*).
- **Asking for corresponding functions / domains of behavior and experience:** Asking openly for corresponding cognitions, emotions, behavior and physical experiences; e.g. *T: "How did you <u>feel</u> when you ..."*, when the patient is reporting a <u>thought or an action</u>; *"Which <u>thoughts</u> were going through your mind in this situation?"* when the patient is reporting what he <u>felt or what he did</u>.
- **Working with images:** Creating together with the patient images for important experiences that can be used as skills (e.g. *"A little goblin who is sitting in the ear and whispering"* for craving, *"to grab the goblin by the scruff of the neck and make it silence"* for coping with craving). Images work the best when metaphors are used that the patients are reporting by themselves or that they accept spontaneously and experience directly as their images. When working with metaphors it is important to take care to which extent the patients are suggestible and whether they are in a sufficiently stable emotional state to tolerate the emotional intensity of images.
- **Giving constructive criticism:** Describing the specific problematic behavior of the patient (*T: "You told me that at the moment it is difficult for you to clear your mind after work and that you start yelling at your partner when you come home and you provoke a quarrel. This is very painful for your partner ... "*), searching together for solutions and approaching the problem (*T: "What do you think about that we discuss any possibilities that might help you to change the situation?* [after the patient has answered] *In order to solve difficult problems it is advisable to look at them carefully and thoroughly. Could you please tell me how it was when you came back home yesterday evening ... "*).

- **Admitting ones own limits and weaknesses, and promising to search for solutions of open questions** (*T: "Well, I must admit that at the moment I have problems to find an answer for your question; I will reconsider once more unhurriedly / talk about it with the other therapists and if you feel like we will talk about this topic at the next appointment."*).
- **Apologizing for mistakes** (e.g. being late, having offended the patient) (*T: "I have hurt you with this statement. I am very sorry for this."*).
- **Finishing the session in an orderly fashion:** Short summary of the session, e.g. the topics, agreements, planned homework, next appointment; shortly mentioning the intake of supervised disulfiram and handing over the urine specimen cup *(T: "Well, it is time to finish the session. Let me briefly summarize what we were talking about … and tomorrow, you wanted to address the issue of looking for a new apartment; as a first step you wanted to compile a list with all of your furniture…. You have already taken you Antabuse, and here is the urine specimen cup for today's urine sample … [*then the usual parting ceremony]").
- **Functional therapeutic beliefs:** (1) I accept the patients how they are; (2) the patients are in therapy because of problems and because they have psychiatric disorders; therefore, they have a right to: show symptoms of the disorder or the recovery process, e.g. being impulsive, overstrained, being anxious, complaining, being reluctant, crying, scolding, shouting, being angry, being desperate, hopeless, to relapse, feeling blocked, being inhibited, silent, weak, undecided, to doubt, hesitate, making no progress, repeating mistakes, not understand, repeatedly tell the same stories: it is all right that they do all these things. (3) In principle the patient has the potential to overcome his / her problems, to develop new and healthy behaviors and to be happy; (4) to overcome serious problems takes time and it is associated with relapses.
- Whenever possible, therapists should avoid: (1) embarrass the patient; disrespect the patient; reject; telling off; snub; accuse; asking in an investigative or inquisitorial way, performing fast cross-examination; (2) overcharge, press, and push the patient to therapy success; force the patien to talk about problems; (3) making helpless statements, being pessimistic (*"With this problem, I can not help you either"*), well-intended joining in moaning ("O *my god, how terrible, o my god …* "); (4) making the patient passive, irresponsible and helpless by taking over / relieve the patient of responsibility; perform problem-solving that the patients could do by themselves; (5) being indifferent, uninterested, or inattentive, e.g. searching files during the session, answering the phone, leaving the room, looking in a bored way at the watch, extensively yawn; (6) treating the patient like a buddy (*"How are you, old fellow!"*), supporting dysfunctional behavior (e.g. giving a certificate of alcohol abstinence after the patient relapsed).

Box 2 Therapeutic communication and interaction skills to build a successful working alliance - Example of a short OLITA therapy session (*T: Therapist; P: Patient*).

T: Good morning, Mr. X. [*Discreet politeness*]

P: Good morning.

T: May I first give you your water with disulfiram so that we are done with the medication? [*Start with self-evident routine – therapeutic ritual*]

P: [drinking the water with disulfiram] Of course, thank you.

T: How are you doing today?

P: Well, I am so-so. Today, I feel already better, but yesterday I visited the social services department because of my new apartment. And the official in charge told me that the rent for the flat would be too expensive, for about 50 Euro. But I need a new place as soon as possible, and it has been so difficult to find this one at all.

T: Right, I remember that you were so glad when you finally had found something suitable. The official's reaction must really have felt like an insult to you" [*Empathic listening / having compassion*]

P: To be honest, yes.

T: Did you find a solution with the official?

P: Well, nearly. We agreed that I can take the flat but I have to pay the lacking 50 Euro, even though I actually do not have the money. All-in-all, this was too much for me, and yesterday night I was again worrying and being angry.

T: Um. I guess there was probably a lot going through your mind. Which worries did you have?

[*Empathic listening / asking open questions*]

P: I don't care anyhow; I have to manage everything on myself. I have never had any support of anybody else.

T: That's right. You have to find a solution yourself. What we can now do together is to think about what would be good for you and what is doable. [*Acceptance, see functional therapeutic beliefs/sharing responsibility*]

P: I have got a lot on my plate recently. I am worrying how everything will develop and so on, and with my job and all these things.

T: Um, um. [*Attentive listening, genuine interest*]

P: Job, apartment, money.

T: Um. Somehow all these things are related with each other. Let us look at how it is going with your work recently. You told my colleague a few days ago that you might have a chance to get a new job. How was it going on? [*Summarizing feedback / responsibility and professionalism*]

P: Well, it does not look so bad, fortunately. The day before yesterday I had a job interview, and I think that it has worked out well so far. I would not earn as much money as in the past, but at least I could afford the apartment. This is why I was thinking about whether I should wait until I will know that I get the job and then I would accept to take the apartment.

T: Yes, this is a very good idea. By doing this you are already making a lot to solve your problems – and you cover both searching a job and finding an apartment - awesome! To what extent is it possible to let the landlord wait for some time?

[*Give feedback on strength and efforts/affirmation and encouraging*]

P: Um, well, tomorrow I am supposed to get a message on whether they will hire me or not. This should be all right. I only hope that everything will go well.

T: Um, I will keep the fingers crossed. What would happen if it wouldn't work out with the job? Would you be so unhappy that you would be at risk for relapse? [*Showing solidarity / directive but careful managing of therapy process*]

P: Oh, I do not know exactly. Probably I would tell myself that I will make it even less with alcohol. The time when I was drinking, I did hardly get anything done.

T: Um. This is great that you are so honest. And you are giving an essential argument for maintaining abstinence. For me and my colleagues it is always important to mention that you can call us whenever you feel unwell, for example after you would get a job rejection. At which time will you get the feedback of the interview? [*Supportive intervention*]

P: They wanted to call me tomorrow at 10 o'clock.

T: What do you think about that we would arrange your tomorrow's OLITA appointment at 12 o'clock, so that we can talk about the result of your telephone call? [*Supportive intervention*]

P: Sounds good to me. In case it works, you can join being happy, and in case it would not work...

T: Then it would be good to have an immediate appointment at OLITA. We would look which other alternatives may exist for you. With your rich work experience and qualifications it will look quite well. But let us wait until tomorrow; I think that you have good chances to get the job. [*Supportive intervention / open feedback of resources*]

P: Right, I do not have to already think about a rejection right now, we will see tomorrow. I will come at 12 and I will discuss the results with you.

T: You are doing a real good job in how you approach your tasks; from my point of you, you are really profiting from being sober. [*Open feedback of resources / praising*]

P: Yes, and I notice how I am recovering physically. And other people seem to notice, too. Even my neighbor said recently that I am looking better than in the past, and she thinks that I am so much better.

T: Great! [*Compassion*] How did you feel when she said this? [*Asking for corresponding domains of experience and behavior*]

P: That is true, I was rather happy about this. It shows that my decision to go to therapy was right.

T: Um, I fully agree, you are in the right track. And when you keep on working on your recovery like you already do, you will rather quickly overcome your current problems with work and apartment. [*Open feedback on strengths and efforts / affirming and encouraging*] Well, here is your urine specimen cup. We already re-arranged the date of your next appointment from tomorrow at 9.30 to 12.00, so we will meet again tomorrow at 12.00. Have a nice day! [*Finishing session in an orderly fashion*]

P: Thank you, have a nice day, too.

In practice, therapist rotation works by the team consistently keeping to a given procedure. The therapists alternate in irregular order between the individual therapy sessions. Patients are not able to designate which therapist they will talk to and as a rule also do not know which therapist they will meet at their next appointment. One therapist does not carry out more than three to four successive sessions with a patient. Joint talks of several therapists with one patient are possible and often help to surmount problems in the relationship at an early time-point. The departure from the team of one therapist and the integration of a new colleague are not regarded as a necessary evil but as a special case of rotation. Patients this way learn and train a functional handling of parting from someone and of separations and establishing of new interpersonal relationships.

While presenting the therapist rotation in hospitals, outpatient facilities and congress meetings, one question is being asked again and again: How is it actually possible for several therapists to treat the same patient without causing confusion in the therapeutic process? It is mainly three aspects that contribute to creating multiple therapeutic relationships:

- **Transparency:** On the one hand it is of great importance to maintain the highest possible degree of transparency to avoid a loss of information. For this, intensive and detailed handing-overs are necessary. OLITA has two extensive team meetings every week, one of 3 h and the other of 1.5 h of duration; short handing-over meetings are added if required. Each therapeutic contact with patients is documented in writing so that every therapist is able to work with the up-to-date state of the therapy. OLITA's documentation is short and concise, it is supposed to inform about the current state of the patient, about changes or stability in the therapeutic process (e.g. present treatment focus, course of the session, therapeutic relationship) and new agreements (e.g. homework, future topics).
- **Congruence:** Amongst the therapists an agreement about the basic elements of the therapy is essential, e.g. congruent presentation of essential concepts like substance abuse, dependence, chronic disease, relapse or handling of alcohol-containing food. By this congruence of concept, the therapists render possible an equally congruent development of therapy processes. No single reference therapist, but the team as a whole, converts into an important therapeutic entity for the patients. In order not to endanger this congruence, it is of utmost importance for every therapist to act as a member of the team. This way, causing damage to the therapeutic relationship of other team members is prevented (e.g. no criticising of other therapists' decisions in front of patients; accurate presentation of team decisions, i.e. "we have decided...", instead of "I have decided...".
- **Training of therapists via therapist rotation:** The patients are used to working jointly with several therapists. This way, the OLITA setting offers itself in an exceptional way for the training of new team members. During the first 2–3 weeks, new therapists participate in as many therapeutic sessions as possible, in an observing role. They introduce themselves to the patients, provide information about themselves and apart from that limit themselves to listening closely and to observing. After several therapeutic ses-

sions with an individual patient, they start to contribute to the conversation, for instance by asking interested questions. Between therapeutic sessions and during team meetings, the experienced therapists have the opportunity to explain their approach, to make comments and to discuss with the new colleagues. During the subsequent weeks the new therapists take over the therapy sessions and the experienced therapists change into the role of observer; this way the young colleagues' approach can be shaped jointly. The main focus here lies on conveying how the basic variables of client-centered therapy can be realized by a team and which special consequences this implies for building multiple therapeutic alliance: As in dyadic therapies, the therapists start with learning that they may be and should be "*authentic*", e.g. disclosing their feelings to an interested patient and not concealing them or trying to mislead the patient. For the team, this authenticity additionally means that all therapists have to act transparently, unitarily, consistent amongst themselves, and not grossly contradictory. Given the fact that patients experience *unconditional acceptance and positive regard* by a number of therapists, the confidence-building effect of these therapy factors is enhanced. A generally warm and trust-inspiring atmosphere is the basis for working with several therapists on topics especially marked with shame (e.g. the recounting of humiliating experiences during former drinking excesses). In a practical sense, *empathy* represents a transformation of acceptance into actions. During the therapy sessions the therapists try to understand the patients in their internal reference frame and to indicate a complete acceptance of the patients' experiences. According to our clinical impression, this uniquely curative experience of being understood and unconditionally accepted by a whole group of people contributes to stabilizing the patients' emotional regulation, to causing an increase in self-esteem and to functionally reorganizing the self concept, thus altogether resulting in a maturation of the patients' personality.

- **Mechanisms of action of therapist rotation:** In spite of the strong focus on congruent processes, this does not mean that any therapist has to renounce her/his own personal views and preferred therapeutic procedures when faced with problems. It is exactly this difference between individual therapists that foster – under the prerequisite of a basic congruence – the positive consequences of the therapist rotation.

In order to describe the interplay of similar and diverse processes in OLITA, two central common factors were postulated:

1) **Congruence and repetition:** Certain therapeutic processes and topics are principally carried out in correspondence and are frequently repeated.
2) **Variety and variation:** The patients meet various statements and actions of different persons in order to provoke within the framework of fundamental congruence a variation of the most important topics of the therapy and thus a discussion of new aspects, interpretations and possibilities of behavior.

5. Integration of client-centered and cognitive-behavioral therapy elements in different treatment phases

Depending on the treatment phase, client-centered or cognitive-behavioral therapeutic elements are predominant in OLITA (Fig. 2). The first 6 months of treatment are characterized by a client-centered approach,[1] where the formation of a therapeutic alliance between therapist and patient is granted highest priority.

5.1. *Intensive and stabilizing phase*

In the initial phase of the therapy, the main psychotherapeutic aim of the OLITA team is to establish, in spite of a strict regulation and structuring, a working alliance with the patient. For this reason, all therapists introduce themselves to the patient already during the inpatient phase in one-on-one conversations, and the principle of work according to therapist rotation is explicitly addressed. The team places great emphasis on showing an alliance-enhancing communication and interaction behavior. The art here consists in translating abstract factors of the therapeutic alliance into specific actions, attitudes and feelings. Box 1 shows important facets for alliance building interventions, and box 2 presents a fictional example of a therapy conversation that implements these therapeutic communication skills. The common aim of the alliance-building interventions is to activate the various constructive aspects of the interactions between patient and therapist.

At the beginning of therapy, when the biological stress tolerance of patients still is severely impaired,[4] a supportive and non-demanding approach has proven very effective. This assists the continuous slow establishment of problem coping and problem solving skills without overtaxing the patient. A stable working alliance is the core of supportive psychotherapy. It represents the most important therapeutic resource, which comes into play when coping with acute burdening experiences so that early therapy dropouts and relapses can be prevented. The team members for this reason are guided mainly by the basic variables of client-centered therapy in order to create a non-confrontational and trusting collaboration with the patients (Fig. 1). The primary aims at this stage of therapy are challenging: Solving of specific everyday problems, motivating towards maintaining abstinence and continuation of the therapy, prevention of stressful emotional turmoil, stabilization of the still very "fragile" abstinence and in general surmounting the initially high state of demoralization of the patient. The patients determine the topics of sessions and the therapists deliberately refrain from inquiring more deeply. The only therapeutic rule concerning topics during the first 3 months is that in every session the word "alcohol" has to be mentioned at least once. This prevents a "fading of the alcohol problem" against the background of overwhelming acute psychosocial difficulties and helps the patients to develop a stable awareness of their alcohol dependence. Using all disposable external and internal resources, the therapists assist in the development of self-esteem and the experience of self-efficacy. Such explicit use of resources

is a therapeutic attitude which, working on an *outpatient basis* with severely dependent patients, nearly becomes a matter of course. For this reason, the therapists learn the approach of resource orientation very easily when they have to make existential decisions every day during the short daily contacts. In the first 6 months of therapy many patients frequently undergo risky situations and crises that require a fast and creative approach: "*Is a patient in danger of a relapse or at suicide risk? How can outpatient care best be continued during the crisis? Is it sufficient to intensify the outpatient contact frequency or is a short inpatient period necessary for crisis intervention? Which bridge will be accepted most readily by the patient? What therapy successes is he most proud of? What is especially important to him? What could fascinate him and move him to continue treatment?...*". The patients and the team are busy daily to determine all factors that would be beneficial for a continuation of abstinence, the recognition of what has already been achieved and, finally, for survival. This point of view strengthens the therapists' awareness of the resources of patients and their environment.

The therapist rotation has especially proven its worth in situations of crisis during the early phase of abstinence. The team will be able to analyse the situation jointly, to plan the most important subsequent steps and to share the work. While, for example, two therapists extensively take care of the patient in crisis, the rest of the team looks after the other patients. This flexible collaboration, however, is only possible if it previously has been made sure that the patients have a trusting relationship with all therapists.

In summary, it can be stated that during the first 6 months of OLITA, a client-centered approach is predominant. Cognitive behavioral elements, however, even in the beginning of treatment provide a framework for the program, e.g. the clear orientation towards abstinence, the strict therapy rules (like short sessions, no missing of an appointment) or the control elements (application of alcohol deterrents, urine analysis for alcohol, aggressive aftercare [this is an intensification of outreach interventions, see Table 2; in aggressive aftercare it is attempted by all disposable means to *instantaneously* interrupt beginning and to prevent threatening relapses by the use of telephone calls, various spontaneous house-visits, involvement of relatives and letters]).

5.2. *Weaning-off and aftercare phase*

During the first year of OLITA the therapeutic sessions are slowly tapered off by a reduction of contact frequency and the patients visit once weekly the OLITA group, a mutual help group with a supporting therapist which prepares the attendance of traditional self-help groups after the end of the therapy. Parallel to the patients' increasing tolerance level for stress the therapists complement the supportive interventions with more profound cognitive behavioral interventions which start, according to the patients' individual capacity, from about month 6 of the therapy (Fig. 1). At this point, the topics of therapy are extensive analyses of subjective relapse situations and individual etiological factors of addiction, optimizing and maintaining of relapse prevention strategies, identification and change of dysfunctional cognitions and interaction patterns as well as integration and stabilization of a functional disease model. Further aims in OLITA phases III and IV are the improvement of communication and interaction problems (mainly concerning partnership and family problems), social skills training, as well as the explicit treatment of comorbid psychiatric disorders. Therefore, classical cognitive behavioral interventions are adopted, e.g. exposure therapy in anxiety disorders or activity scheduling and cognitive restructuring in mood disorders. It is of utmost importance to embed these interventions into the overall therapy program and to adjust it to the individual patient. Alcohol relapses caused by a too fast or too stressful approach have to be avoided at all cost. For this reason, the therapists have to recall at all times that chronic alcohol dependent patients are in the first place severely addicted persons who manifest a long-lasting inability to cope with stress. A relapse may mean acute mortal danger for most of them. The relapse risk increases in emotionally stressful situations, e.g. after an exposure training or after a confrontation with dysfunctional beliefs or painful experiences of the past. For this reason the team forgoes any mulish working through therapy manuals and uses the whole spectrum of OLITA elements delineated above to give the patient the necessary support during the treatment of critical disease aspects or of crises. A temporary increase of session frequency has proven especially effective, as have the possibility for telephone contacts and personal crisis interventions, but also apparently simple factors like the mere fact that through the control elements of the program (supervised disulfiram intake, urine analysis for alcohol) drinking is no longer an option as a solution to temporary stress, or rather, has become extremely unattractive. This way, there is a "gentle enforcement" to explore new possibilities for a solution, to test them and to apply them again and again.

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